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HEALTH
EDUCATION
AND WELFARE

Indicators

August 1965

Medicare – Social Security Amendments of 1965

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the Under Secretary

HEALTH, EDUCATION, AND WELFARE INDICATORS

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THE SOCIAL SECURITY AMENDMENTS OF 1965

Wilbur J. Cohen and Pearl Peerboom

The Social Security Amendments of 1965 became Public Law No. 97 (89th Congress) on July 30, 1965, when President Lyndon B. Johnson approved H.R. 6675.

The Amendments constitute a major milestone, comparable in significance to the adoption of the original Social Security bill in 1935, on the road to achievement of security in old-age.

Sitting beside President Johnson, in the Truman Library, Independence, Missouri, former President Truman watches the signing into law of the Medicare bill. Mrs. Truman, Mrs. Johnson, and Vice President Humphrey also look on as "this time of triumph" is shared with the former president, who proposed similar legislation for health care of the aged 20 years ago.

Mr. Cohen is the Undersecretary of Health, Education, and Welfare, and Mrs. Peerboom is a Research Analyst on his staff.

REMARKS BY PRESIDENT JOHNSON

UPON SIGNING THE SOCIAL SECURITY AMENDMENTS OF 1965

Independence, Missouri, July 30, 1965

It was a generation ago that Harry Truman said, "Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection."

. . . today, . . . we are taking such action 20 years later. . . . The need for this action is plain . . .

There are more than 18 million Americans over the age of 65. Most of them are threatened by illness and medical expenses that they cannot afford . . .

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will meet the fees of the doctors . . .

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

ADVANCING THE NATION'S HEALTH
(SPECIAL MESSAGE TO CONGRESS)
January 7, 1965

Thirty years ago, the American people made a basic decision that the later years of life should not be years of despondency and drift. The result was enactment of our social security program, a program now fixed as a valued part of our national life. Since World War II, there has been increasing awareness of the fact that the full value of social security would not be realized unless provision were made to deal with the problem of costs of illnesses among our older citizens. . . .

I ask that our social security system--proved and tested by three decades of successful operation--be extended to finance the cost of basic health services. . . .

I consider this measure to be of utmost urgency. Compassion and reason dictate that this logical extension of our proven social security system will supply the prudent, feasible, and dignified way to free the aged from the fear of financial hardship in the event of illness. . . .

LYNDON B. JOHNSON

The main provisions of the new law--the broadest social security act in the Nation's history--are designed to provide protection for the Nation's workers and their families against the high cost of health care in old age, to increase cash benefits under social security and make other substantial improvements in the old-age, survivors, and disability insurance program, to provide for more adequate medical and income help for the needy, and to improve the health care of handicapped children.

Although the Senate had made 513 amendments to the bill as it came from the House, the major features of the House and Senate versions were not widely different in overall effect, and the House-Senate Conference Committee reconciled the differences in record time.

Two related new contributory health insurance programs for aged people are established: (1) a basic plan providing hospital insurance and related care financed jointly by employers and employees through social security payroll taxes; and (2) a voluntary supplementary plan to cover physicians' services and other medical services not covered by the basic plan, financed by monthly premium payments of $3 by each

Public Law 89-97

I HEALTH INSURANCE AND MEDICAL BENEFITS
- Hospital Insurance Basic Plan
- Voluntary Supplementary Plan
- Medical Assistance

II OTHER HEALTH AMENDMENTS
- Maternal and Child Health Services
- Mental Retardation Planning
- Mental and TB Diseases

III SOCIAL SECURITY CASH BENEFITS
- 7% Benefit Increase
- Wage Base to $6,600
- Transitional Insured Status
- Lower Age for Widows
- Retirement Test Liberalization
- Child's Benefits to Age 22
- Disability, Coverage, and Other Changes

IV PUBLIC ASSISTANCE AMENDMENTS
- Increased Federal Matching
- Protective Payments
- Exempt Certain Earnings in Determining Need
- Other Changes

SUMMARY OF MAJOR PROVISIONS

Basic Health Plan, financed under social security, covering hospitalization, nursing home care, outpatient diagnostic, and home health services.

Supplemental Voluntary Health Plan, covering doctors' fees and some additional health services.

Kerr-Mills, expanded program of medical assistance for the needy aged, dependent children, blind, and permanently and totally disabled.

Other Changes Related to Health Care, providing assistance for needy aged patients in hospitals for tuberculosis and mental disease, an expansion of maternal and child health and crippled children's services, and an extension of mental retardation planning authorization.

Retirement, Survivors and Disability Benefits, 7 percent monthly increase with a minimum increase of $4 a month, retroactive to January 1, 1965.

Earnings Base, Increasing from $4,800 to $6,600 the total annual earnings on which social security contributions and benefits are based, effective January 1, 1966.

Revised Tax Schedule, provides for 4.2 percent each for employee and employer (and 6.15 percent for the self-employed) on earnings up to $6,600, effective January 1, 1966, with ultimate increase to 5.65 percent each for employer and employee (7.8 percent for self-employed) in 1987.

Transitional Insured Status for persons aged 72 and over so that three, four, or five quarters of coverage will qualify them for monthly social security benefits of $35 ($17.50 for a wife; $35 for a widow).

Retirement Test, changing the provision for withholding benefits because of earnings so that a beneficiary who earns above $1,500 in a year (rather than the former $1,200 exempt amount) has $1 in benefits withheld for each $2 of earnings between $1,500 and $2,700 (rather than between $1,200 and $1,700 as under previous law) and $1 for each $1 of earnings above $2,700.

Lower Age for Widows, with reduced benefits available as early as age 60.

Benefits for Children to Age 22, if regularly attending school.

Coverage, extension to include the earnings of doctors and of employees who receive tips, and exemption from coverage for the Amish and similar sects conscientiously opposed to acceptance of the benefits of any public or private insurance.

Disability Benefits, changing eligibility requirements so that any person with a disability lasting 12 months or expected to result in death could get benefits, rather than (as under prior law) that the disability be of long-continued and indefinite duration (or expected to result in death).

Public Assistance Amendments, increasing the Federal share of payments for the needy aged, blind and disabled and disregarding certain earnings in determining a person's need for assistance.

FIRST-YEAR EFFECT OF NEW PROVISIONS [1]

	Additional benefits payable (millions)	Number of people affected (000's)
Basic Hospital Plan	$2,500	19,000
Supplemental Plan	1,070	15-18,000
Medical Assistance	200	8,000
Maternal and Child Health Services	60	
Mental Retardation Planning	3	
Social Security Benefit Increase	1,470	20,000
Retirement Test	295	750
Lower Age for Widows	165 [2]	185
Transitional Insured Status	140	355
Definition of Child	10	20
Child's Benefits to Age 22	195	295
Disability Benefits	45	67
Public Assistance Amendments:		
Increased PA Payments	150	7,200
TB and Mental Disease	75	130
Earnings Exemptions	1	
Definition of MAA	2	

[1] Total first year cost estimated--$6.46 billion.

[2] No long-range cost to the system because the benefits are actuarially reduced.

enrollee matched by an equal amount from Federal general revenues. In addition, the amendments provide for an expanded medical assistance program of Federal grants to the States for medically indigent aged, blind, and disabled people and for dependent children and their parents.

HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE (Title I of P.L. 89-97)

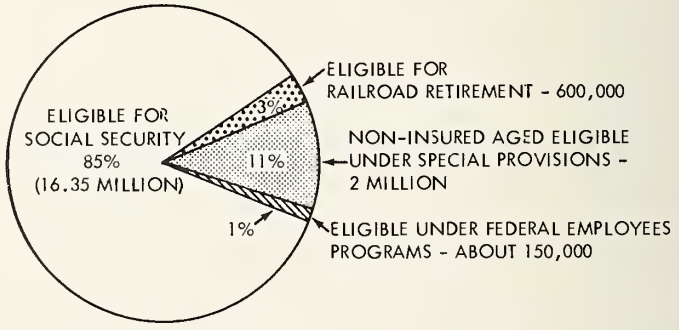
Under title I, the Health Insurance for the Aged Act, a new title XVIII is added to the Social Security Act providing two separate but complementary health plans for meeting the national problem of adequate medical care for the aged.

BASIC PLAN--HOSPITAL INSURANCE (Part A of Title XVIII of the Social Security Act)

The basic hospital plan consists of contributory insurance protection for aged people against the costs of hospital and related care.

The plan applies to all people aged 65 and over who are eligible for monthly social security or railroad retirement benefits (about 16.9 million people). The same protection extends also to other aged people not social security or railroad retirement beneficiaries (about two million people).

HOSPITAL INSURANCE FOR PERSONS 65 AND OVER


ELIGIBLE FOR SOCIAL SECURITY 85% (16.35 MILLION)
3%
ELIGIBLE FOR RAILROAD RETIREMENT - 600,000
11%
NON-INSURED AGED ELIGIBLE UNDER SPECIAL PROVISIONS - 2 MILLION
1%
ELIGIBLE UNDER FEDERAL EMPLOYEES PROGRAMS - ABOUT 150,000

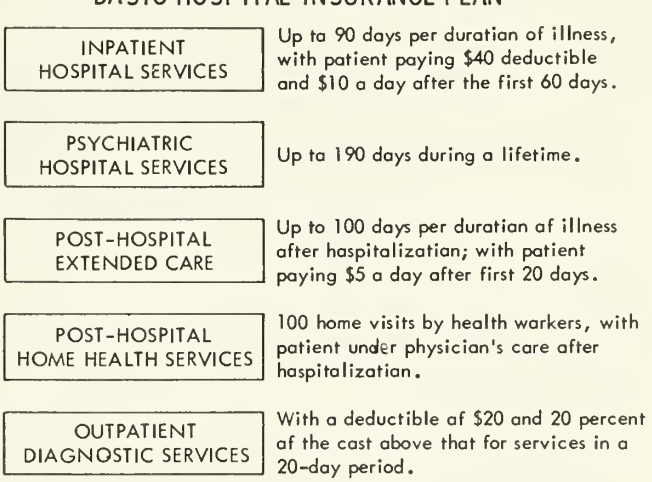
TOTAL AGED 19.1 MILLION - JULY 1966

Beginning in July 1966, as part of the social security system, the plan is financed through a new special earnings tax paid by employers, employees, and the self-employed. The hospital insurance tax contributions are to go into a trust fund kept entirely separate from other funds of the system. The cost of benefits for aged people not insured under the railroad retirement or social security system will be paid from General Funds of the Treasury.

The basic plan covers: Up to 90 days of hospital care for each duration of illness, with the patient paying a deductible amount of $40 for the first 60 days plus $10 a day for the 61st and subsequent days. (Inpatient psychiatric hospital services are covered, with a lifetime limit of 190 days on such coverage. Inpatient tuberculosis hospital services are also included, and the cost of any blood after the first three pints furnished to a patient during a given illness); Up to 100 days of extended-care services in a qualified nursing home or other facility, after three or more days of hospitalization, with a coinsurance payment by the beneficiary of $5 for each day of extended care beyond the 20th day (effective January 1, 1967);

Up to 100 health services (such as a visiting nurse) to a homebound patient following discharge from a hospital (after at least a three-day stay) or extended-care facility; And outpatient hospital diagnostic services with the patient paying a $20 deductible amount and a 20 percent coinsurance payment for services by the same hospital during a 20-day period.

The less expensive alternatives to inpatient hospital care are intended to promote the most efficient and economical use of existing health-care facilities while enabling the beneficiaries to have the kinds of services and levels of care most appropriate to their needs.


BASIC HOSPITAL INSURANCE PLAN
INPATIENT HOSPITAL SERVICES
Up to 90 days per duration of illness, with patient paying $40 deductible and $10 a day after the first 60 days.
PSYCHIATRIC HOSPITAL SERVICES
Up to 190 days during a lifetime.
POST-HOSPITAL EXTENDED CARE
Up to 100 days per duration of illness after hospitalization; with patient paying $5 a day after first 20 days.
POST-HOSPITAL HOME HEALTH SERVICES
100 home visits by health workers, with patient under physician's care after hospitalization.
OUTPATIENT DIAGNOSTIC SERVICES
With a deductible of $20 and 20 percent of the cost above that for services in a 20-day period.

All costs for benefits under the basic plan (and for administration) will be paid from the Hospital Insurance Trust Fund. The annual earnings subject to the health insurance tax beginning in 1966 will be $6,600 a year, the same as for financing social security cash benefits. The hospital insurance contribution rates apply equally to employees, employers, and self-employed people and are based on estimates which assume that hospital costs will continue to rise faster than earnings for the next 10 years, at the same rate as earnings after 1975, and that the earnings base will not be increased above $6,600. If Congress should subsequently raise the base above $6,600, the tax rates scheduled could be reduced.

Hospital Insurance Tax-Rate Schedule

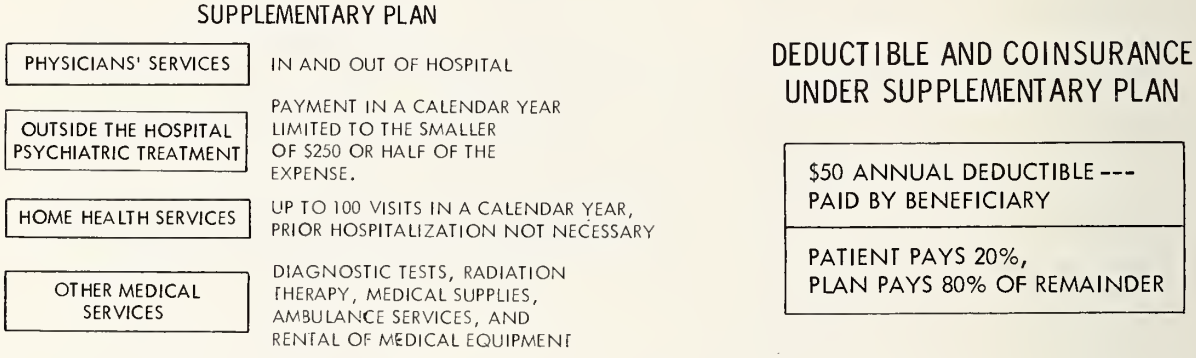
Year	Percent
1966	.35
1967-1972	.50
1973-1975	.55
1976-1979	.60
1980-1986	.70
1987 and after	.80

Responsibility for administering the basic plan rests on the Secretary of Health, Education, and Welfare to be carried out through the Social Security Administration with appropriate State agencies and private organizations assisting in the administration. Hospitals could, for example, elect to be represented by a private organization (such as Blue Cross); the Secretary could also delegate to such an organization the function of receiving payments from the social security program.

SUPPLEMENTARY PLAN--VOLUNTARY MEDICAL INSURANCE
(Part B of Title XVIII of the Social Security Act)

The voluntary supplementary insurance plan provides medical insurance administered through private carriers to all residents of the United States aged 65 and over. Beginning in July 1966, and subject to a $50 deductible to be paid by a patient in a calendar year, the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere; home health services (with no requirement of prior hospitalization) for up to 100 visits during each calendar year; diagnostic X-ray and laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; ambulance services; surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, and eyes. A special limitation is placed on payment for outside-the-hospital treatment of mental, psychoneurotic, and personality disorders; during any calendar year the limit is $250 or 50 percent of the expenses, whichever is smaller.


SUPPLEMENTARY PLAN
PHYSICIANS' SERVICES
IN AND OUT OF HOSPITAL
OUTSIDE THE HOSPITAL PSYCHIATRIC TREATMENT
PAYMENT IN A CALENDAR YEAR LIMITED TO THE SMALLER OF $250 OR HALF OF THE EXPENSE.
HOME HEALTH SERVICES
UP TO 100 VISITS IN A CALENDAR YEAR, PRIOR HOSPITALIZATION NOT NECESSARY
OTHER MEDICAL SERVICES
DIAGNOSTIC TESTS, RADIATION THERAPY, MEDICAL SUPPLIES, AMBULANCE SERVICES, AND RENTAL OF MEDICAL EQUIPMENT
DEDUCTIBLE AND COINSURANCE UNDER SUPPLEMENTARY PLAN
$50 ANNUAL DEDUCTIBLE --- PAID BY BENEFICIARY
PATIENT PAYS 20%, PLAN PAYS 80% OF REMAINDER

People who enroll initially would pay monthly premiums of $3, deducted (where possible) from social security, railroad retirement, or civil service retirement benefits. A Federal payment matching the $3 monthly premium per enrollee will be paid from the General Funds of the Treasury to help finance the Supplemental Plan. To provide an operating fund at the beginning of the program and to establish a contingency reserve, a Government appropriation will be available (on a repayable basis) equal to $18 per aged person estimated to be eligible in July 1966, when the Supplemental Plan goes into effect. Individual and Government contributions are to be placed in a separate trust fund for the Supplemental Plan, with all benefit and administrative expenses paid from this fund.

Since the minimum increase in cash social security benefits would be $4 for a retired person aged 65 or over and $6 for a couple, the benefit increase would fully cover the monthly premiums for social security and railroad retirement beneficiaries. Aged public assistance recipients who are not entitled to social security could be enrolled in the supplementary plan by the State agency, which would pay contributions for the recipient out of its State-Federal assistance funds. Various protections against adverse selection are included in the enrollment provisions. For example, there is a waiting period before a newly enrolled person becomes eligible for payments, making it unlikely that he could delay enrollment until expensive health services were required. This reduces the possibility of people enrolling in the program after their health deteriorates, thus increasing program costs by covering people during periods of ill health who chose not to be covered during periods of good health.

As under the basic plan, overall responsibility for administering the supplementary plan rests with the Secretary of Health, Education, and Welfare. To the extent possible, he must contract with intermediaries to carry out the major administrative functions of the plan such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance, assisting in utilization review, assisting in the application of safeguards against unnecessary use, and assuring that payment for a service is on a reasonable cost or charge basis.

GENERAL PROVISIONS RELATING TO THE TWO HEALTH INSURANCE PLANS

Payments to hospitals and other providers of services shall be the reasonable cost of the services furnished. The cost of hospital services would be based on semi-private accommodations (two, three, or four-bed rooms).

FINANCING OF 2 HEALTH INSURANCE PROGRAMS

PLAN	SOURCE OF FUNDS	SCHEDULE
Basic Hospital Insurance	Employee, Employer & self-emplayed cantributions General revenues far transitianal insured status	Each pays 1966 - 0.35% Rising ta 0.80% in 1987 an $6,600 earnings base
Supplementary Medical Insurance	Beneficiary and Federal Government	Each pays $3 monthly

Each hospital or extended-care facility must have in effect a utilization review plan to review admissions, duration of stays, the professional services furnished with respect to the medical need for them, and to promote the most efficient use of available facilities and services.

Health facilities generally operate under licenses issued by State governments; and State public health authorities generally inspect these facilities to determine whether they conform with requirements of the State licensing law. Administration of the Health Insurance for the Aged Act will capitalize on this experience by using State agencies to determine which providers of health services meet the appropriate definitions and to consult with hospitals or other facilities that wish to partipate in the program.

In addition to requiring the Secretary, in carrying out his administrative responsibilities, to consult with appropriate State agencies, national and State associations or providers of services, and recognized national accrediting bodies, the law also requires the appointment of two advisory groups made up of experts from outside the Government:

A Health Insurance Benefits Advisory Council of 16 persons to advise the Secretary on general policy matters in the administration of the health insurance programs; and

A National Medical Review Committee of 9 persons to study the use of insured hospital and other medical care and services.

TESTIMONY BEFORE THE SENATE COMMITTEE ON FINANCE, April 29, 1965

No other social security amendments have approached the scope of these proposed amendments. For older people, for widows and orphans, and for the disabled and their families, the payment of benefits where none is now available would turn despair into hope. Every community in our Nation would share in the good that the bill would do.

Anthony J. Celebrezze
Secretary of Health, Education, and Welfare

MEDICAL ASSISTANCE PROGRAM
(Title XIX of the Social Security Act)

In order to provide a more effective program of medical care for needy persons, a new title XIX of the Social Security Act establishes a single and separate medical-care program, which improves and expands various provisions for the needy previously covered under five different titles of the Social Security Act.

The new title extends the advantages of an expanded medical assistance program not only to the needy aged, but also to people receiving assistance under the programs of aid to families with dependent children, the blind, and permanently and totally disabled,and to people who would quality under these programs if their needs were sufficiently great.

Inclusion of aged people who are not on the cash assistance rolls but who do not have enough income to meet medical care cost is optional with the States; if they are included, comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. (States electing to include aged patients in mental and tuberculosis hospitals will not have to include similar care and services for people under age 65--this is an exception to the general requirement that the amounts, scope, and duration of benefits under title XIX be the same for all groups.) Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients of cash assistance. As an interim measure, States have the option of adopting the medical assistance program under the new title XIX: Grants to the States for Medical Assistance Programs, or of continuing to operate under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program). After December 31, 1969, grants for medical vendor payments will be made only under title XIX.

The Federal share of medical assistance expenditures under the new program would vary in relation to a State's per capita income with no maxium on the amount of such expenditures in which there would be sharing. Financial participation by the State shall be not less than 40 percent of non-Federal share of the expenditures under the plan, and effective July 1, 1970, all the non-Federal share shall be from State funds. In order to receive any additional Federal funds as a result of expenditures under the program,the States

The provision of health insurance for the aged, together with the important improvements made in the existing social security cash benefit program, will greatly strengthen the protection of American workers and their families. This broadened and strengthened protection is a gratifying expression of the Nation's confidence in its chief program for preventing dependency and want. It is also a stern challenge to those of us who are entrusted with administering the program. We will strive to meet these new responsibilities in a way that will prove worthy of that trust.

--Robert M. Ball
Commissioner of Social Security

would need to continue expenditures at the previous rate. This provisior is intended to assure that lack of local funds for financing any part of the program will not affect the amount, scope, or duration of benefits, or the level of administration set by the State. A State plan will not be approved if operation of the proposed State program would result in reducing assistance under the basic maintenance assistance programs. In order to continue to receive Federal funds under the new title, the States would need to show progress toward a goal of comprehensive care and services to substantially all needy individuals under its program. The greatest number of new potential beneficiaries under the expanded benefits would be the 3.2 million dependent children now receiving financial aid and any other children from broken families who need help if their medical needs are to be met.

The new title prohibits the imposition of durational residence requirements. No liens would be imposed against the property of a recipient during his lifetime for assistance correctly paid. Also, no recovery can be made of any medical assistance correctly paid except from the estate of a person over the age of 65 at the time he received medical assistance, and then only after the death of surviving spouse and minor children. Only income which is actually available may be considered in determining need and any resources of the individual must be reasonably evaluated. States may not take into account the financial responsibility of any individual for anyone who is not a spouse,or child under the age of 21,or blind,or disabled.

By July 1, 1967, a minimum medical-assistance program would be required to include at least some inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing home services, and physician's services regardless of where they are provided. States could, at their option include a broad range of other medical services, such as dental services, prescribed drugs, eyeglasses (prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the patient may elect), dentures and prosthetic devices. A State must also establish and maintain standards for institutions providing medical care. (The Secretary of Health, Education, and Welfare is authorized to establish standards relating to protection against fire and other hazards to health and safety.)

The States are required to use professional medical personnel and supporting staff in the administration of the program, with 75 percent reimbursement of the cost for training as well as compensation of such personnel, whether on

the State or local staff, by the Federal Government. The State agency administering the program must also make cooperative arrangements with health and vocational rehabilitation agencies, and establish other standards and methods designed to assure quality. In developing its plan for medical services under title XIX, States must show that in their plans eligibility for care and services will be determined in a manner consistent with simplicity of administration and the best interests of the recipient. The State, in determining eligibility and the medical assistance to be provided, must pay for those who are eligible, any deductible imposed under the Hospital Insurance provisions of the bill.

If the State plan provides medical assistance to people in mental hospitals, the State is also required to provide the medical and related services needed, and to be working toward a comprehensive mental health program in the State. The availability of Federal funds for the cost of medical assistance paid in behalf of such persons is contingent upon a corresponding increase in total expenditures in the State for mental health services. Under the new title XIX, a State may designate any single State agency for administration, but determination of eligibility must be made by the agency administering the old-age assistance program.

CHILD HEALTH AND WELFARE
(Title II of P.L. 89-97)

MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES (Title V of the Social Security Act)

The amounts authorized for maternal and child health services are increased by $5 million (to a total of $45 million) for the fiscal year ending June 30, 1966, and by $10 million for succeeding fiscal years. The increased authorizations are intended to assist the States to move toward the goal of extending maternal and child health services to make them reasonably available to children in all parts of the State by July 1, 1975. Preventive health services can be provided for more mothers and children, thereby contributing to further reduction of infant and maternal mortality.

The amounts authorized for crippled children's services are also increased by $5 million (to a total of $45 million) for 1966, and by $10 million for succeeding fiscal years. The increases are intended to assist the States in extending crippled children's services to areas of a State not now served, to make needed care available to many crippled children and to children with potentially crippling conditions (e.g. to children with hearing defects, epilepsy, or strabismus, neglect of which may result in loss of vision of the affected eye). The increased funds also help States extend their programs to urban areas and further broaden their definition of "crippling" until all State programs serve children with any kind of handicapping condition or long-term illness. Effective July 1, 1967, States would be required under the maternal and child health and crippled children's

services program to pay the reasonable costs of hospital services provided under the State plans.

Funds are authorized for training professional personnel for the care of crippled children, $5 million for fiscal year 1967, $10 million for 1968, and $17.5 million for each fiscal year thereafter. The program will help reduce the severe shortage of professional personnel to deal with mentally retarded children and children with multiple handicaps. Grants will be made to institutions of higher learning for training physicians, psychologists, nurses, dentists and social workers for work with crippled children, particularly mentally retarded children and children with multiple handicaps. Such grants are expected to greatly accelerate training now provided to a limited extent in clinics and university centers from funds from the Department of Health, Education, and Welfare programs operating under existing authority.

A new five-year program of special project grants for low-income school and preschool children will provide comprehensive health care and services for children of school age and for preschool children, particularly in areas with concentrations of low-income families. Projects would provide screening, diagnosis, and preventive services for all children; treatment, correction of defects and after-care is limited to children in low-income families. The program would reduce the numbers of children of preschool and school age who are hampered by remediable handicaps and provide necessary medical care for children of low-income families who would otherwise not receive care. Effective health supervision for children during the years before entering school will help considerably in getting them ready for school and will reduce the extent of the need for school health services for children in the first year of school.

An appropriation of $15 million would be authorized for the fiscal year ending June 30, 1966, $35 million for 1967, $40 million for 1968, $45 million for 1969, and $50 million for 1970.

Grants covering up to 75 percent of the cost of approved projects would be available to the State health agency or, with its consent, to the health agency of any political subdivision of the State, to the State agency administering or supervising the crippled children's program, to schools of medicine (with appropriate participation by schools of dentistry) and to teaching hospitals affiliated with schools of medicine. Project applications must show how services will be coordinated with other State health, education, and welfare programs to make possible programs organized to make optimum use of available community services and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals.

A full report on the program, including evaluation and recommendations must be made to Congress prior to July 1, 1969.

In addition, grants are authorized for studies of resources for emotionally disturbed children.

Appropriations of $500,000 each for fiscal years 1966 and 1967 are authorized for grants for such studies. Upon recommendation of the National Advisory Mental Health Council and in consultation with experts in pediatrics and child welfare, the Secretary of Health, Education, and Welfare is authorized to make grants to conduct research into and study of resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illnesses. Such grants may be made to a nongovernmental agency, organization, or commission composed of representatives of leading national medical, welfare, educational, and other professional associations, organizations, or agencies active in the field of mental health of children.

IMPLEMENTATION OF MENTAL RETARDATION PLANNING
(Title XVII of the Social Security Act)

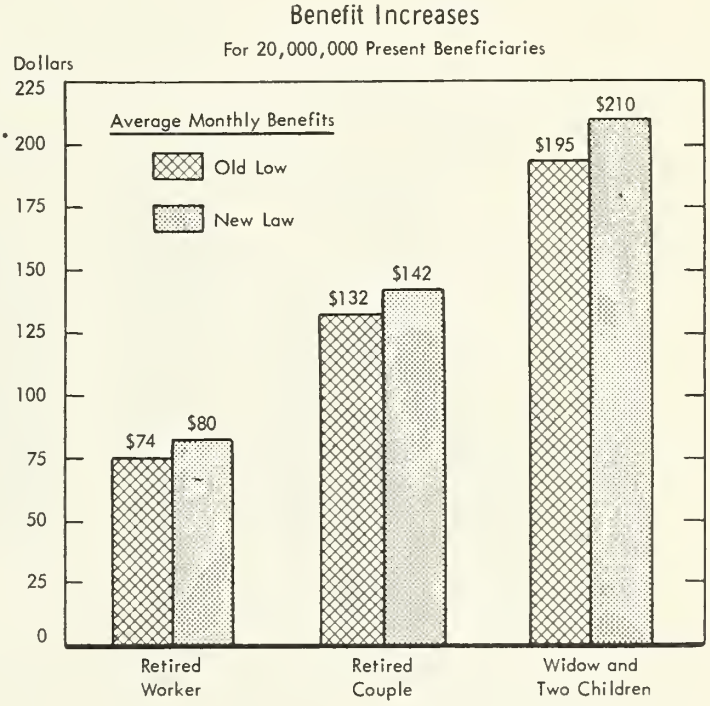
Grants of $2.75 million a year for 1966 and 1967 are authorized to assist States in following up and beginning to implement the comprehensive plans to combat mental retardation that have been developed under legislation enacted in 1963.

SOCIAL SECURITY AMENDMENTS
(Title III of P.L. 89-97)

Title III, the Old-Age, Survivors, and Disability Insurance Amendments of 1965, provides for far-reaching and comprehensive amendments to title II of the Social Security Act. Social Security benefits would be increased 7 percent (with a guaranteed $4 a month minimum increase for a retired or disabled worker and $6 for a couple) for the 20 million social security beneficiaries. The last general benefit increase was enacted in 1958, and the 7 percent increase takes into account increases in prices since that time. The minimum primary benefit is increased from $40 per month to $44;

the maximum from $127 to $135.90. The average primary benefit would be increased from about $74 to about $80. In the future, creditable earnings under the increase in the contribution and benefit base to $6,600 a year (from $4,800) would make possible a maximum benefit of $168.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all levels. The highest family maximum would be $368. Under prior law, the $254 limit on family benefits operated over a wide range of average monthly earnings. Benefit increases would be paid retroactively to January 1, 1965, with the increased benefits for the retroactive months paid in a separate check.

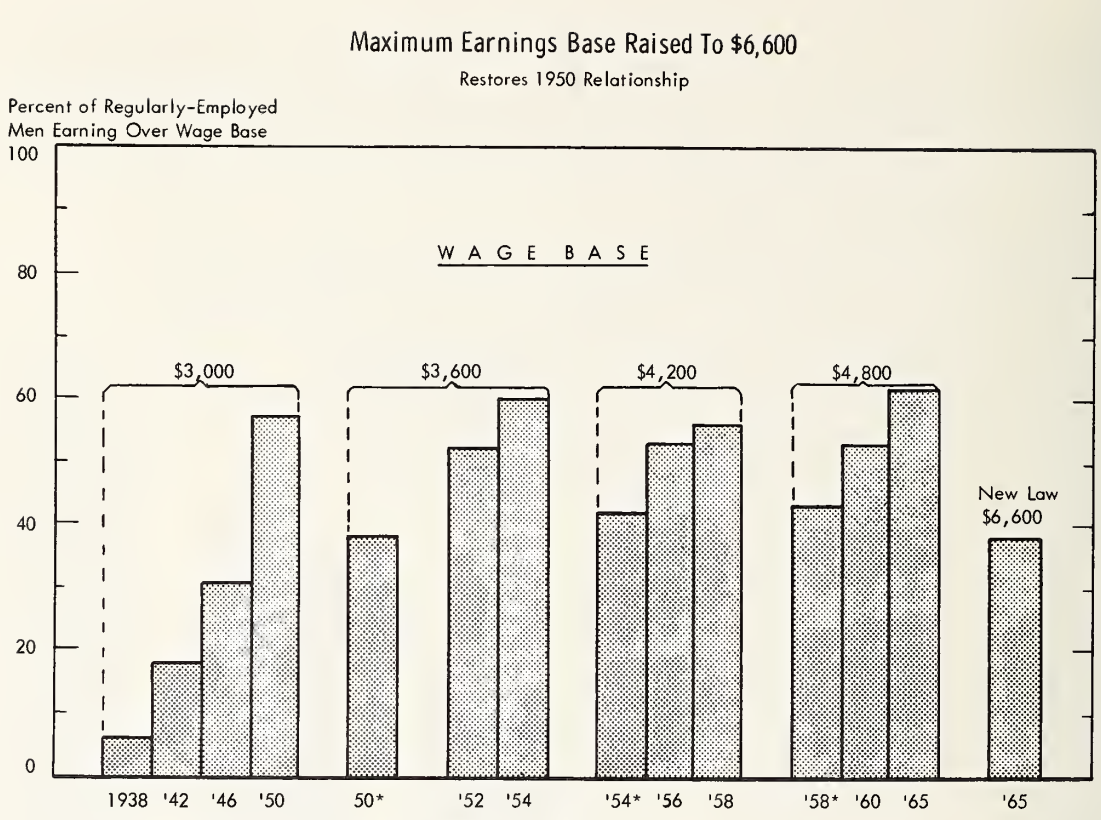


In 1965, an estimated $1.2 billion in additional benefits would be paid as a result of the 7 percent increase; in 1966, $1.5 billion in additional benefits would be paid.

The maximum annual earnings on which taxes and benefits are computed would be increased from $4,800 to $6,600 a year, effective January 1, 1966. Increasing the limitation on annual earnings used to figure benefits and taxed to support the program makes it possible for workers at and above average earnings levels to have benefits more reasonably related to their actual earnings; also, taxing a larger part of the Nation's payrolls will improve the financial base of the program.

As a result of the increase to $6,600 a year in the amount of covered earnings taxed and credited toward benefits effective January 1, 1966, some 29 million people will have earnings in excess of $4,800 credited to their social security accounts in 1966. Old-age, survivors' and disability insurance benefits, within limits, vary with the worker's previous earnings. Since benefits are related to past earnings, the basic factor in the determination of benefit amounts is the level of previous earnings. More than 64 percent of the male workers regularly employed and covered by the program now earn more than the $4,800 earnings base provided under the 1958 amendments.

The congressional committees took the position that, if the principle that benefits should vary with earnings is to be maintained, earnings above the $4,800 limit must be counted toward benefits in the future. Raising the



earnings base to $6,600 restores approximately the same relationship between general earnings levels and the maximum earnings base that existed in 1950. In 1965 approximately 38 percent of the regularly employed male workers covered by social security had earnings of more than $6,600, and in 1950 about 38 percent earned above the $3,600 base in effect at that time.

When the social security program was enacted in 1935, the $3,000 base provided would have covered the full earnings of 97 percent of regularly employed men. A base of about $15,000 would be needed now to be comparable to the $3,000 base original situation with respect to the proportion of total earnings covered under the program.

The revised tax-rate schedule (combined for social security and hospital benefits) would be:

	Employer-employee Rate each (Percent)			Self-employed rate (Percent)		
Year	OASDI	Hosp.	Total	OASDI	Hosp.	Total
1966	3.85	.35	4.2	5.8	.35	6.15
1967-1968	3.9	.5	4.4	5.9	.5	6.4
1969-1972	4.4	.5	4.9	6.6	.5	7.1
1973-1975	4.85	.55	5.4	7.0	.55	7.55
1976-1979	4.85	.6	5.45	7.0	.6	7.6
1980-1986	4.85	.7	5.55	7.0	.7	7.7
1987 and after	4.85	.8	5.65	7.0	.8	7.8

Benefits for Children Aged 18-22. Benefits are extended to child beneficiaries aged 18 to 22 regularly attending school, effective January 1, 1965. It is estimated that 295,000 children will be eligible for benefits for September 1965, when the school year begins.

No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

Broadened Definition of a Child--Benefits would be paid to a child based on his father's earnings even though the child cannot inherit the father's intestate property, if the father had acknowledged the child in writing, been ordered by a court to contribute to the child's support, had been judicially decreed to be the father, or is shown by other reasonable evidence to be the father and was living with or contributing to the support of the child. An estimated 20,000 people, children and their mothers, will become immediately eligible for benefits. Approximately $10 million will be paid in 1966.

Benefits for Widows at Age 60--Benefits will be available to widows at age 60, with the benefits actuarially reduced to take account of the longer period of time over which they will be paid. (Prior law provided for full widows' benefits starting at age 62.) An estimated 185,000 widows aged 60-61 on the effective date of the provision are expected to claim benefits. Payments estimated at $165 million will be made in 1966.

Retirement Test--The provision for withholding benefits because of a beneficiary's earnings is changed to exempt the first $1,500 of earnings (rather than $1,200 as in prior law) and to withhold $1 in benefits for each $2 of earnings between $1,500 and $2,700 (this span was $1,200 to $1,700 in prior law), with a $1-for-$1 adjustment above that level. For 1966, an estimated $295 million will be paid to workers and their dependents, who either will receive more benefits under the new test than they would have received under prior law, or will receive some benefits where they would have received no benefits under the old test.

Transitional Insured Status--People aged 72 or over before 1969 qualify for monthly social security benefits of $35 if they have three, four, or five quarter-year periods of social security coverage (the number needed depending on a person's age). These quarters could be acquired at any time since the beginning of the program in 1937. Wives of workers who qualify under this provision would be eligible for benefits of $17.50 (one-half of the amount of the husband's benefit) if they reach age 72 before 1969. Widows would receive $34 a month under the provision. Some 355,000 persons aged 72 and over will become immediately eligible for benefits. Payments of $140 million will be made under this provision in the first full year of operation.

Disability Benefits--The amendments eliminate the requirement that a person's disability must be of long-continued and indefinite duration and provide that an insured worker is eligible for benefits if his disability is expected to result in death or to last 12 months. An estimated 60,000 people--disabled workers and their dependents--will be eligible for benefits. Payments under the provision will amount to $40 million in 1966.

Eligibility requirements for payment of disability benefits to blind workers were also changed. The definition of disability is liberalized for older blind persons, and the time that younger blind persons must have worked in jobs covered by social security to qualify for disability benefits is reduced. An estimated 7,000 people--blind workers and their dependents--will become immediately eligible for benefits. Payments under this change will amount to $5 million in 1966.

In cases where disability payments duplicate workmen's compensation, the social security disability benefit will be reduced so that the combined benefits are limited to 80 percent of the worker's average salary over the five years prior to his becoming disabled; reduction will be periodically adjusted to take account of changes in earnings levels.

The cost of rehabilitation services furnished to disability insurance beneficiaries by State vocational rehabilitation agencies are to be paid from the social security trust funds to State agencies on a reimbursement basis. The total amount of the funds made available in any year for reimbursing State agencies for rehabilitative services could not exceed one percent of the social security disability benefits paid in the previous year.

Benefits for Divorced Women--Wife's or widow's benefits will be paid to the divorced wife of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making a substantial contribution to her support (or was ordered by a court to do so). A wife's benefits will not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a divorced wife, a widow, or a surviving divorced wife who remarries and the subsequent marriage has ended.

Continuation of Widow's Benefits after Remarriage--Benefits are payable to widows aged 60 or over (and to widowers aged 62 or over) who remarry. The amount of the remarried widow's (or widower's) benefit is equal to 50 percent of the primary insurance amount of the deceased spouse rather than 82½ percent of that amount, which is payable to widows and widowers who have not remarried. This provision remedies a hardship situation under prior law in which a widow's (and widower's) benefits based on a deceased worker's social security earnings record generally stopped when the survivor remarried, with the result that some widows who would have liked to remarry did not because they would have lost their social security benefits.

Coverage Changes--The new law extends social security coverage to self-employment income from the practice of medicine and to the wages of interns, covers tips as wages, facilitates coverage of additional State and local government employees, provides additional coverage for employees of certain nonprofit organizations, extends coverage to temporary employees of the District of Columbia, increases the amount of gross income which farmers may use under the optional method of computing farm self-employment income for social security purposes, and permits exemption from the social security self-employment tax for members of certain religious sects.

Approximately 170,000 doctors of medicine would have their self-employment income covered on the same basis as the self-employment income of other professional groups. (More than half of the physicians in private practice have obtained some social security credits through work other than their self-employment as physicians, or through their military service.)

Coverage is also extended to services performed by medical and dental interns on the same basis as other employees working for the same employers.

Tips are covered as wages for social security and income-tax withholding purposes, except that employers will not be required to pay the social security employer tax on the tips. The new provision is intended to correct the situation under which more than a million employees covered under the social security program had an important part of their income from work excluded from coverage because it was received in the form of tips.

Exemption from Coverage for the Amish and similar sects conscientiously opposed to the acceptance of the benefits of any public or private insurance is provided on an individual option basis; the contribution exemption applies only to self-employment tax. Before an individual could be granted exemption, he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person. An individual's exemption (and the waiver of social security benefits) would be terminated if he no longer met the conditions on which the exemption was based, and he could not again obtain an exemption.

Ministers--A new provision reopens through April 15, 1966, the period in which ministers who have been in the ministry for at least two years since 1954 may file waiver certificates electing social security coverage; coverage will ordinarily begin with 1963. In addition, social security credit is to be obtained for the past earnings of certain ministers who die or file waiver certificates before April 16, 1966, where such earnings were reported for social security purposes but could not be credited under prior law.

Farmers--Farm operators whose annual gross earnings are $2,400 or less (instead of $1,800 or less as in prior law) can report either their actual net earnings or 66-2/3 percent of their gross earnings. Farmers whose annual gross earnings are over $2,400 will be required to report their actual net earnings if $1,600 or more, but if actual net earnings are less than $1,600, they may report either actual net earnings or $1,600. (Present law requires that farmers whose annual gross earnings are over $1,800 report their actual net earnings if $1,200 or more, but if actual net earnings are less than $1,200, they may report either their actual net earnings or $1,200). The provision is effective for taxable years beginning after December 31, 1965.

State and Local--Alaska is added to the list of 18 States which may extend social security coverage to only those current members of a retirement system who desire such coverage, with compulsory coverage for all persons who later become members of the retirement system. Further changes were made in coverage provisions applying to Alaska, Iowa, North Dakota, California, and Maine.

Under Payments--The new law contains a provision which authorizes the Secretary to dispose of amounts due a deceased beneficiary, where such amounts do not exceed the amount of the beneficiary's monthly benefit, by making the payment to the widow or widower who was living in the same household with the beneficiary; if there is no such widow or widower, or if the underpayment exceeds the amount of one month's benefit, the amount due generally will be paid to the legal representative of the deceased person's estate.

Combined Check--A temporary overpayment may now be authorized to permit a surviving spouse to cash a benefit check issued jointly to a husband and wife if one of them dies before the check is negotiated, on the condition that any resulting overpayment would be recovered.

Filing of Proof--Extends, where good cause exists, the period of filing proof of support for dependent husband's, widower's and parent's benefits, and lump-sum death payments.

Automatic Recomputation of Benefits--The retirement benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Under prior law there were various application requirements, including filing of an application and earnings of over $1,200 a year after entitlement.

Attorneys' Fees--A Federal court that renders a favorable decision to a claimant in an action arising under the social security program is authorized to set a reasonable fee (not in excess of 25 percent of past due benefits which become payable as a result of the decision) for the attorney who represented the claimant. The Secretary is authorized to certify payment of the fee to the attorney from past-due payments.

An Advisory Council on Social Security is to be established in 1968 and every fifth year thereafter to review the entire social security and health insurance program and to make a report to Congress. Prior law required the appointment of Advisory Councils on Social Security Financing to report on the financing of the program in 1966 and every fifth year thereafter.

PUBLIC ASSISTANCE AMENDMENTS
(Title IV of P.L. 89-97)

INCREASED ASSISTANCE PAYMENTS

The Federal share of payments under all State public assistance programs is increased about $2.50 a month for the needy aged, blind, and disabled, and an average of about $1.25 for needy children, effective January 1, 1966. The cost from general revenue will be about $150 million a year.

In the adult categories the first fraction would become $31 of Federal funds for $6 of State and local funds in place of the present $29 for $6. The maximum subject to Federal participation on an average basis would be increased from $70 to $75. In aid to families with dependent children the first fraction would become $15 Federal and $3 State in place of the present $14 for $3. The aid to families with dependent children average maximum per recipient would be increased from $30 to $32. States would not receive additional Federal funds except to the extent that their expenditures increase.

PATIENTS IN MENTAL AND TUBERCULOSIS HOSPITALS

Federal funds to the States would be authorized for aid to the needy aged in mental or tuberculosis institutions, effective January 1, 1966. The cost from general revenues will be about $75 million a year.

Persons in general medical institutions because of a diagnosis of tuberculosis or psychosis (including blind and disabled recipients under titles X and XIV) would also be eligible for payments including Federal participation. In order to qualify for Federal participation, the State plans would have to include provisions designed to insure the best possible care for individual recipients, including alternatives to institutional care. States would also have to be making satisfactory progress in developing comprehensive mental health programs, including community mental health centers. States would receive Federal funds only to the extent that they increase their expenditures for mental health purposes under public health or public welfare programs.

PROTECTIVE PAYMENTS FOR AGED, BLIND, OR DISABLED PERSONS

Protective payments for aged, blind, or disabled persons would be authorized effective January 1, 1966. The welfare agency may make protective payments on behalf of a needy person who is unable to manage his funds because of physical or mental incapacity to another individual interested in or concerned with the welfare of the needy person.

The singificant advances in public welfare and child health programs made possible through the Social Security Amendments of 1965 will mean more complete and adequate medical care for millions of Americans who otherwise would not receive it, more financial help for those who are the poorest of the poor, and substantially increased health and welfare services for children. We are indeed given the opportunity to take major strides toward assuring for many more of our citizens lives of dignity and health.

-- Ellen Winston,
Commissioner of Welfare

INCOME EXEMPTIONS

Old-Age Assistance--The earnings exemption under the old-age assistance program (and aged in combined programs) is increased, effective January 1, 1966, so that a State may, at its option, exempt the first $20 (now $10) and one-half of the next $60 (now $40) of a recipient's monthly earnings. The cost is estimated to be about $1 million for the first year.

Aid to Families with Dependent Children--The State may, at its option, disregard up to $50 per month of earnings for each of not more than three dependent children in the same home, effective July 1, 1965. The cost is estimated to be $1.3 million for the first full year of operation.

Aid to the Permanently and Totally Disabled--An exemption of earnings may be made, at the option of the State, for recipients of aid to the permanently and totally disabled. As in the case of the aged, the first $20 per month of earnings and one-half of the next $60 could be exempted. Any additional income and resources could be exempted as part of an approved plan to achieve self-support during the time the recipient was undergoing vocational rehabilitation.

Old-Age and Survivors Insurance (retroactive increase)--The States may disregard as much of the old-age, survivors, and disability insurance benefit increase (including payments for children in school beyond age 18) as is attributable to its retroactive effective date.

Economic Opportunity Act Earning Exemption--A grace period is provided for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under titles I and II of the Economic Opportunity Act.

Income Exempt Under Another Assistance Program--Any amount of income which is disregarded in determining eligibility for a person under one of the public assistance programs shall not be considered in determining the eligibility of another individual under any other public assistance program.

JUDICIAL REVIEW OF STATE PLAN DENIALS

A State dissatisfied with the Secretary's decision with respect to a State plan under the Social Security Act or with his action under such programs or non-compliance with State plan conditions in the Federal law may appeal to the courts for a review of the Secretary's decision or actions. A limitation of 30 days is placed on the time between the Secretary's receipt of a petition from the State and the time that a hearing is set.

DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

The definition of medical assistance for the aged is changed so as to allow Federal sharing in both old-age assistance and medical assistance for the aged in the first and last month of care in a medical institution, effective July 1, 1965. The cost in both is estimated to be about $2 million a year from general revenues.

SIGNIFICANT DATES AND EVENTS LEADING TO ENACTMENT OF A PROGRAM OF HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

The issue of providing medical care for the people of the United States has been one of growing concern to the Congress over the past twenty years. In 1945 (also in 1947 and in 1949), President Truman proposed--without success--a broad medical insurance plan. Even earlier, such a plan had been endorsed by many congressmen and various bills to provide for it had been introduced.

1935

January 17: The *Report of the President's Committee on Economic Security* was sent to Congress and formed the basis of the Social Security Act passed later in the year. The report endorsed the principle of compulsory national health insurance but made no specific program recommendations. In submitting his report, President Roosevelt said, "I am not at this time recommending the adoption of so-called 'health insurance,' although groups representing the medical profession are cooperating with the Federal Government in the further study of the subject, and definite progress is being made." It has been reported that national health insurance was not recommended because the controversial nature of the proposal might have prevented enactment of the entire Social Security Act. Also available medical facilities were believed to be inadequate for a health insurance program. First priority was given to improving and expanding them through public health facilities grants, which were included in the Social Security Act.

1943

The first "Wagner-Murray-Dingell" bill (S. 1161 -- H.R. 2861) was introduced by Senators Robert F. Wagner of New York, James E. Murray of Montana, and Representative John D. Dingell, Sr. of Michigan. The bill provided for major changes in the Social Security Act and for creation of a compulsory national health-insurance system for all people. The program was to have been financed through a payroll tax. Congress took no action on the proposal.

1944

January 11: President Roosevelt outlined in his *State of the Union Message,* an "economic bill of rights," which included "the right to adequate medical care and the opportunity to achieve and enjoy good health." However, he did not subsequently make any proposal for health insurance.

January 19: The Social Security Board, in its *Eight Annual Report* to Congress, specifically called for compulsory national health insurance to be incorporated into the Social Security system.

1945

January 6: President Roosevelt in his *State of the Union Message* again referred to the right to "good medical care" but made no specific recommendations.

June 3: Senators Wagner and Murray and Representative Dingell reintroduced, as S. 1050 and H.R. 3293, the same program they had sponsored in 1943.

November 19: In a special message to Congress, President Truman proposed a comprehensive, prepaid medical insurance plan for all people, through the social security system. The plan would have covered doctor, hospital, nursing, laboratory and dental services for people covered by the social security program; it would also have provided benefits financed from general Federal revenues for needy people. Mr. Truman's proposal was immediately introduced by Senators Wagner and Murray as S. 1606 and by Representative Dingell as H.R. 4730.

1946

S. 2143, authorizing some $230 million a year in Federal grants to the States for comprehensive medical care for people who could not otherwise afford it, was introduced by Senator Robert A. Taft of Ohio, who opposed the President's proposal as a "socialistic measure." The bill, which also allowed States to pay part of private health insurance premiums for those who needed help in meeting the cost, was endorsed by the American Medical Association.

Congress conducted hearings both on the Taft bill and on the Administration's proposal, but took no further action.

1947

President Truman, in a special message to the Republican-controlled Congress, again, requested and Senators Wagner and Murray sponsored (S. 1320) a compulsory national health-insurance program. Senator Taft also reintroduced (S. 545), his version of a health bill. The 80th Congress conducted hearings on the bills, but did not act on them.

1949

January 5: In his *State of the Union Message* (delivered this time to a Congress with Democratic majorities in both houses), President Truman again called for compulsory national health insurance for persons of all ages, financed by a Federal payroll tax.

April 22: The President, in a special message, repeated his request for national health insurance. Organized labor, many northern Democratic Congressmen and private organizations of professional workers in the social welfare field favored broad Federal responsibility in this area. They backed proposals for a compulsory national health-insurance system financed by a Federal payroll tax (like the social security payroll tax) that would pay the costs of health services for most people, without regard to age or means. President Truman, on a number of sequent occasions, continued to urge the Congress to enact such legislation.

Hearings were held on S. 1679 and H.R. 4312, bills sponsored by Senators Murray and Wagner and Representative Dingell and others, to achieve the Administration's proposal. The hearings evoked sharp controversy and severe criticisms of the Administration. There were strong advocates of national health insurance, headed by the Committee for the Nation's Health--an *ad hoc* organization whose leaders included Eleanor Roosevelt, attorney Abraham Fortas, Chester Bowles, Russell Davenport, Mrs. Leon Keyserling, AFL and CIO Presidents William Green and Philip Murray, Mrs. Albert Lasker and Robert F. Wagner, Jr. The AFL, CIO, Americans for Democratic Action, Physicians Forum, National Farmers Union, American Veterans Committee, Consumers Union, the railroad unions and American Association of Social Workers endorsed the proposal.

The American Medical Association was strongly opposed to a national health insurance program. Other groups testifying against enactment of the program included the American Dental Association, American Pharmaceutical Association, Blue Cross-Blue Shield Commissions, Chamber of Commerce of the U.S., Committee for Constitutional Government, American Legion, American Farm Bureau Federation, National Grange, General Federation of Women's Clubs, Health Insurance Council, Health and Accident Underwriters Conference, and National Catholic Welfare Conference.

After extensive consideration of the controversial issue, Congress took no action in either chamber on the bills.

1950

President Truman repeated his earlier request for compulsory national health insurance, but Congress again failed to act on it.

H.R. 6000 providing Federal grants to States for medical care of public assistance recipients was enacted and became the 1950 Social Security Act Amendments (P.L. 81-734). Under the new law, Federal matching grants could be made to the States, not only for direct payments for living expenses of dependent children and the needy aged, blind, and disabled but also for "vendor payments"--payments for treatment of people on public assistance made by the State directly to doctors, nurses and health-care institutions.

1952

February 26: Federal Security Administrator Oscar Ewing, in a speech to B'nai B'rith women's group in New York, proposed a substitute measure limited to payment through the Social Security system of hospital costs for retired beneficiaries and their dependents as a step toward a larger goal. S. 3001, H.R. 7484 and H.R. 7485, embodying Mr. Ewing's proposal, were introduced by Senator James E. Murray of Montana, Representatives John Dingell of Michigan and Emanuel Celler of New York. No Congressional action was taken on the Murray-Dingell-Celler bills in 1952.

During his campaign for President, Dwight D. Eisenhower opposed compulsory national health insurance as "socialized medicine," but he promised to help needy persons meet the costs of health care.

1954

January: President Eisenhower, with the objective of enabling private insurance companies to broaden their coverage, proposed Federal reinsurance for any private company as protection against heavy losses on health insurance. After the first five years, the program could be self-financing with funds derived from premiums paid by the insurance companies. H.R. 8356 and S. 3114 were introduced as the Administration's proposals.

May 17: Following a meeting with President Eisenhower, the executives of 17 life insurance companies issued a statement "favoring the general objectives of the bill." The Eisenhower proposal was sharply criticized by the American Medical Association as "the opening wedge toward socialized medicine," and as leading to Federal domination of the insurance field. A number of insurance industry spokesmen also opposed the measure.

The Committee for the Nation's Health and spokesmen for organized labor also opposed the reinsurance plan on the basis that it was inadequate and would not result in moderate-cost commercial insurance for such high-risk groups as the elderly and chronically ill, who-although they were most in need of help--could not purchase private insurance. They also expressed the belief that the reinsurance program might prevent enactment of a bill to provide adequately for national health care.

H.R. 8356, the President's reinsurance proposal, was reported by committees of both the House and Senate.

July 13: Following floor debate on the proposal, the House voted 238 to 134 to recommit H.R. 8356, and there was no further action on the bill.

1956

Marion B. Folsom, Secretary of Health, Education, and Welfare, requested Congress to enact legislation proposed in S. 4172, which would permit small insurance companies and voluntary health insurance groups to pool resources in expanding their hospital and medical expenses coverage. Congress did not act on the proposal.

1957

President Eisenhower recommended the proposal made by Secretary Folsom in 1956, but again there was no action by the Congress on the recommendation.

H.R. 9467, a bill proposing the social security approach to health care for the elderly, was introduced by Representative Aime J. Forand of Rhode Island. Organized labor began a public campaign to raise the social security payroll tax and to use the additional proceeds to finance costs of surgery and up to 120 days of combined hospital and nursing-home care for aged social security beneficiaries. Congress took no action.

1958

The Committee on Ways and Means of the House of Representatives held extensive public hearings on proposals for health insurance for the aged, but concluded that more information was needed before any legislation in this field could be recommended. They requested the Secretary of Health, Education, and Welfare to study and report on possible ways of providing insurance against the cost of hospital and nursing home care for social security beneficiaries and on the benefit costs and administrative implications of the different alternatives.

1959

H.R. 4700 was introduced by Representative Forand to provide hospital, surgical, and nursing home benefits for old-age and survivors insurance beneficiaries using the social security administrative mechanism; the program was to be financed by an increase in the social security tax. A number of alternative proposals were subsequently introduced in both the House and the Senate, but were not enacted.

The Senate Committee on Labor and Public Welfare established a special Subcommittee on Problems of the Aged and Aging (the McNamara Subcommittee) to conduct a comprehensive study of the major problems of the aged. The subcommittee held public hearings throughout the country, primarily on the health needs of the aged.

September 3: Report by the Secretary of Health, Education, and Welfare, *Hospitalization Insurance for OASDI Beneficiaries,* to the Committee on Ways and Means of the House of Representatives brought together information on the characteristics of the aged, their income and assets, their use of medical services, and the extent to which they are covered by voluntary health insurance. It also outlined and presented cost estimates for several alternative methods of providing hospital benefits through the Social Security system for aged persons. The report also outlined various methods of stimulating voluntary insurance, subsidies to private insurance carriers, and Federal assistance to the medically indigent but did not recommend specific action.

July: The Secretary of Health, Education, and Welfare testified at the beginning of five days of public hearings on H.R. 4700 conducted by the Committee on Ways and Means:

> "There is general agreement that a problem does exist. The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care needs. As a group they use about two and a half times as much general hospital care as the average for persons under age 65 and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on "free" care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important."

The Secretary did not regard H.R. 4700 as a satisfactory solution to the problem, since he believed that the objective of making adequate medical care available to the aged population should be achieved through voluntary action. He also indicated that there were problems relating to the adequacy and cost of existing health insurance for aged persons and that the Department was continuing to study possible methods of strengthening the voluntary approach.

During the hearings on H.R. 4700, numerous witnesses testified both for and against proposals for health benefits for aged persons through the Social Security system. The American Medical Association, a number of State medical societies, the American Hospital Association, the Chamber of Commerce of the United States, the Health Insurance Association of America, the American Life Convention, the Life Insurance Association of America, and others opposed the Social Security approach, and some opposed any Federal action. Their major arguments related to the fear of Government control of hospital costs and of medical practice, the danger that overutilization of hospital facilities would cause the quality of care to decline, and the fear that hospital insurance for the aged would be but the first step toward Federal health insurance for all. They also raised the question whether the aged were as badly off financially as pictured, and pointed out that the most needy among the aged do not get old-age and survivors insurance benefits and would not, therefore, be helped by a program geared to the social security system.

Those who supported H.R. 4700 testified to the growing need for using the social insurance system to meet the higher-than-average medical costs of the aged. This would assure immediate broad coverage and a mechanism for prepayment without the need for a means test for medical care. They pointed to the shortcomings of private insurance policies and the advantages to hospitals and private insurance carriers if the costs of the aged group were paid by Government. Suggestions were made to drop surgical benefits, and to add outpatient diagnostic and visiting nurse services with the objective of curtailing the use of hospitals. Hearings concluded; no further action occurred that year on proposals for medical care for the aged.

1960

February 15: In its *First Annual Report,* the Special Senate Subcommittee on Problems of the Aged and Aging of the Labor and Public Welfare Committee stated: "The No. 1 problem of America's senior citizens is how to meet the costs of health care at a time when income is lowest and potential or actual disability at its highest. Its solution should have top priority for legislative consideration in 1960."

March 14-June 3: The Committee on Ways and Means of the House of Representatives began hearings and considered possible amendments to the Social Security Act. A large part of the time was devoted to the issue of medical care for the aged. The Committee Chairman requested the Secretary of Health, Education, and Welfare and his technical staff to sit with the Committee during most of its sessions.

March 31: By a vote of 17 to 8 the Ways and Means Committee tabled the Forand proposal for a program of hospital insurance for the aged.

April: The Special Senate Subcommittee on Aging held hearings in Washington, D.C., primarily on the health needs of the aged. The lineup of groups testifying for and against provision of medical benefits through social security was similar to that at the 1959 hearings before the Committee on Ways and Means. Some new information on the medical needs of the aged was introduced; the Secretary of Health, Education, and Welfare again testified that he was exploring various alternatives.

April 7: S. 3350, introduced by Senator Javits and seven other Republican senators, would have provided Federal matching grants to States for the cost of health insurance for persons aged 65 and over. Six identical bills were introduced in the House.

May 4: In testimony before the Committee on Ways and Means, Secretary of Health, Education, and Welfare Arthur S. Flemming, presented the Eisenhower Administration's proposal for a Federal-State program of protection against the cost of long-term and expensive illness for low-income people aged 65 and over. Participation would have been optional with an income test to determine eligibility. The States, the Federal Government (from general revenues) and enrollees (by fees of $24 a year) would have shared in financing a broad range of medical benefits.

May 6: Senator McNamara and 18 other Democratic senators introduced S. 3503, based in part on the hearings of his subcommittee and designed to meet some of the criticisms made of the Forand bill. S. 3503 provided for a special retirement test to determine eligibility for health benefits including hospital and nursing home care, outpatient diagnostic services and the cost of expensive drugs. Benefits for people covered by social security would be paid from increased payroll taxes; for other aged people, from general revenues. Senator John F. Kennedy of Massachusetts had, earlier in the session, sponsored S. 2915, a Senate version of the Forand bill.

July 13: After more than three months' consideration, the Committee on Ways and Means reported to the House H.R. 12580, the Social Security Amendments of 1960. The bill established a new title XVI of the Social Security Act, providing Federal grants to the States to help pay the costs of medical services for aged people not on Public Assistance but unable to meet their medical expenses.

June 23: H.R. 12580 was considered in the House under a closed rule (preventing any amendments from the floor) and was passed, 381 to 23.

June 29-30: The Senate Finance Committee held public hearings on H.R. 12580. In his testimony before the Committee, the Secretary of Health, Education, and Welfare endorsed the proposed medical assistance title. He pointed out, however, that the new program would not help the aged make advance provisions for meeting the costs of illness. He repeated the Administration's objections to the social insurance approach and recommended financing medical care for the aged through general revenues.

June 30: S. 3784, introduced by Senator Saltonstall, was the proposal endorsed by the Administration and described by Secretary Flemming in his testimony on May 4.

The 1960 *Annual Conference of Governors* approved a resolution urging Congress to adopt "a health insurance plan for persons 65 years of age and over to be financed principally through the contributory plan and framework of the old-age, survivors, and disability insurance system." This resolution was submitted to the Senate Committee on Finance.

July 31: Senator Kennedy, the Democratic Presidential candidate, issued a statement saying enactment of some version of his bill (S. 2915) was one of his five chief legislative goals for the August session. (Congress had adjourned for the Democratic and Republican National Conventions with an August date set for reconvening.) In the Senate Finance Committee, Senator Clinton P. Anderson of New Mexico proposed a revised version of the Forand-Kennedy bill as an amendment to H.R. 12580, but it was rejected by a vote of 12 to 5. The Committee, instead, liberalized the medical-care provisions of H.R. 12580.

August 19: The Senate Finance Committee reported out H.R. 12580, with a number of changes in the medical-care provisions.

January: The White House Conference on Aging developed clear-cut evidence that aged people--as a group--have incomes too low to finance their heavy medical costs. The nature and dimensions of the problem were defined in the background papers prepared under the direction of National planning committees and in the factual reports developed by each State.

August 23: On the floor of the Senate three major amendments relating to medical care for the aged were debated. All accepted the medical assistance provisions of the bill as reported by the Finance Committee, but proposed to add other medical care programs. Senator Anderson, with Senator Kennedy's strong backing, offered as a floor amendment a proposal authorizing hospital, nursing home, visiting nurse and outpatient diagnostic services for people aged 68 and over who were eligible for Social Security benefits. The amendment was defeated on a 44 to 51 roll-call vote. Also rejected--by a 28 to 67 vote--was a proposal offered by Senator Javits of New York and backed by Vice President Richard M. Nixon, the Republican Presidential candidate. The Javits amendment combined elements of the Administration's May 4 proposal with his earlier bills which had emphasized Federal assistance to voluntary prepayment health plans for the low-income aged.

An amendment introduced by Senator Long of Louisiana, to permit Federal matching of vendor payments under title I of the Social Security Act to public mental and tuberculosis hospitals, was opposed on the grounds that support of public mental and tuberculosis hospitals was a State responsibility and Federal funds made available to States to improve hospital programs should be direct and not through the public assistance program. The supporters of the amendment cited the great need for additional funds for care of patients with mental illness or tuberculosis and argued that the public assistance program should not discriminate on the basis of type of illness. The amendment was adopted by a vote of 51 to 38.

August 24: The Conference Committee agreed to the medical care provisions added by the Senate except for Senator Long's amendment. A provision in the bill as approved by the House was reinstated, to permit the use of Federal funds for 42 days of medical care of a patient in a general hospital as the result of a diagnosis of tuberculosis or psychosis.

August 26: The Conference Report (H. Report 2165) was approved in the House by a vote of 368 to 17.

August 29: On the floor of the Senate, Senator Long argued against adoption of the Conference Committee report. After extensive debate, the Senate approved the report, by a vote of 74 to 11.

September 13: H.R. 12580 was signed by the President and became Public Law 86-778. The new law provided increased Federal grants to States for medical care programs for aged people getting old-age assistance if the increase was spent on vendor medical payments. In addition, a new program (commonly referred to as "Kerr-Mills") of Federal grants to States for vendor medical care programs for aged people not on public assistance but unable to pay for needed medical services was provided. States participating in the program have wide latitude to determine standards of eligibility for benefits and the medical benefits offered.

November: After his election but before his inauguration, the late President Kennedy--as President-Elect--appointed a *Task Force on Health and Social Security for the American People,* with Wilbur J. Cohen as Chairman. The task force was directed to review from among the most pressing and significant health and welfare proposals those which should have priority in the initial phase of the new administration.

1961

January 10: The *Task Force on Health and Social Security for the American People,* reported to the President. The report made a number of recommendations regarding health care, including a program of hospital insurance for the aged through the social security system.

February 9: The President's *Health Message* (H. Doc. No. 85) was the first message ever to be devoted exclusively to the need for a health care program. To help meet the problem of financing the high cost of illness in old age. President Kennedy recommended the addition of a health insurance program to the existing social security system.

February 13: H.R. 4222, the Health Insurance Benefits Act of 1961, proposing a program along the lines set forth by the President, was introduced by Representative King of California. S. 909, a companion bill, was introduced in the Senate by Senator Anderson. The House bill was referred to the Committee on Ways and Means.

February 13: S. 937, introduced by Senator Javits for himself and eight other Republican Senators, contained essentially the same proposal as the amendment offered by Senator Saltonstall on July 9, 1962. (See below.)

July 24-August 4: The Committee on Ways and Means held public hearings on H.R. 4222, but there was no further Congressional action in 1961 on health insurance for the aged.

After Congress adjourned, the Kennedy Administration pledged a "great fight across the land" for enactment of a hospital insurance program for the aged in 1962.

1962

January 11: In his *State of the Union Message,* the President renewed his 1961 request that the old-age, survivors, and disability provisions of the Social Security Act be amended to provide health insurance protection for the aged.

February 27: The President's *Special Message on Health* (H. Doc. No. 347) reiterated President Kennedy's 1961 request for health insurance protection for the aged through the social security system.

June 11: The House Ways and Means Committee began executive sessions for consideration of the Administration's health insurance proposal in the King-Anderson bill. Numerous other proposals for hospital insurance were also before the Congress. Representing examples of the social security approach, in addition to the King-Anderson bills, were the McNamara bill (S. 65), the Lindsay bill (H.R. 11253--the plan of Governor Rockefeller), and a new Javits bill (S. 2664). The McNamara bill was similar to the King-Anderson bill except that it had no deductible amount, was limited to individuals who had "retired" according to an earnings test, and, through general revenue, extended eligibility beyond the social security and railroad retirement beneficiaries to uninsured "retired" aged people. The Lindsay bill (H.R. 11253) provided a benefit package identical to the King-Anderson bill but added an option of increased cash social security benefits for individuals who had private insurance meeting specified requirements. It, too, covered the uninsured aged out of general revenues through a Federal-State grant-in-aid program. The Javits bill (S. 2664) used social security financing to provide retired aged persons under social security or railroad retirement an option of a short-term no-deductible plan, a long-term with deductible plan, or a cash payment toward a private insurance contract. The bill also authorized such benefits for retired uninsured persons out of general revenue. The first major bill to use the income tax credit approach was the Bow bill (H.R. 10755) and its many companion measures. It provided an income tax credit, or a certificate for purchasing insurance for those without income tax liability, of up to $125 a year for private medical insurance for persons 65 and over, with financing from general revenues.

June 29: Continued inaction by the Committee on Ways and Means prompted Senator Anderson to offer for himself, 20 other Democratic Senators, and five Republican Senators led by Senator Javits of New York, a revised version of the Administration's health insurance bill (S. 909) as a Senate floor amendment to H.R. 10606, the Public Welfare Amendments, then under consideration in the Senate. To meet objections that had been made to certain provisions of S. 909, the Anderson-Javits amendment made several significant modifications in them. These included: (a) health insurance benefits financed from general revenues for aged persons not eligible for monthly cash benefits under the social security or railroad retirement systems; (b) the use of approved private organizations, selected by hospitals or other providers of services, to administer the program; and (c) an option under which beneficiaries could receive the health benefits

through private insurance, group practice, and other voluntary plans, instead of through the Government. Three major alternatives to the Anderson amendment were debated on the Senate floor. The alternatives proposed to meet the need for additional Federal action with respect to financing the health care costs of aged persons either by providing Federal funds to States or by paying a cash supplement to monthly social security benefits to help meet the cost of private insurance.

July 5: Senator Morton proposed an amendment under which States offering approved group insurance plans for the aged through private carriers would have received Federal reimbursement from general revenues up to $125 a year per participant for premiums paid on behalf of eligible aged persons. Participants could have elected either ordinary or catastrophic illness coverage; the amendment was defeated by voice vote on July 6, 1962.

July 9: Senator Saltonstall proposed an amendment that, in lieu of social security financing, would have provided for a program of Federal matching grants (ranging from one-third to two-thirds) to the States for health benefits for the aged. State plans would have been required to offer the aged a choice among: (1) short-term illness benefits, (2) long-term illness benefits, or (3) private insurance benefits. The Saltonstall amendment was defeated by a vote of 50 to 34 on July 12.

July 9: Senator Bush proposed an amendment under which reimbursement from social security trust funds would have been made to aged social security beneficiaries for the cost of premiums up to $9 a month for any guaranteed renewable health insurance. The Bush amendment was defeated on July 13, by a vote of 74 to 5.

July 12: An amendment was proposed by Senator Javits designed to modify the provisions of the Anderson amendment relating to the beneficiaries' option to continue private health insurance protection. Under the Javits proposal, an approved private plan could have provided--in place of the 90-day hospital benefit with a deductible--a 45-day hospital benefit with no deductible. Senator Anderson accepted the proposal and modified his amendment accordingly.

July 13: An amendment offered by Senator Carroll which contained a declaration of congressional intent that enactment of a health insurance benefits program should not result in the loss of any benefits to which an individual may be entitled under a State medical care program was approved by voice vote.

July 17: The Senate by a roll-call vote of 52 to 48 tabled the Anderson amendment. The 87th Congress took no further action on hospital insurance proposals. However, P.L. 87-543 increased Federal participation in the costs to the States of providing medical care for persons on public assistance.

1963

January 14: In his *State of the Union Message,* The President pointed out, "Our working men and women--instead of being forced to ask for help from public charity once they are old and ill--should start contributing now to their own retirement health program through the social security system."

February 21: President Kennedy's proposals for health care for the aged were submitted to Congress in a Special Message on *Aiding Our Senior Citizens.* The program provided for in-patient hospital costs for either (1) up to 90 days with a $10 a day deductible for the first nine days; (2) up to 180 days with the patient paying the first two-and-a-half days of average costs; or (3) all costs for 45 days. The program also provided 180 days of post-hospital nursing home care; 240 home nursing visits; and outpatient diagnostic services with a $20 deductible. Financing was provided by increased social security taxes and raising from $4,800 to $5,200 the amount of annual earnings subject to the tax.

February 21: The Administration's hospital care bill was introduced in the House of Representatives by Representative King (H.R. 3920) and in the Senate by Senator Anderson (S. 880).

Early in 1963, the Administration's proposals for the improvement of public assistance programs for the aged were introduced in the House of Representatives by Congressman Mills (H.R. 5839) and in the Senate by Senator Anderson (S. 880) as The Senior Citizens' Public Welfare Amendments. The proposed amendments would have provided: (1) protective payments for aged persons; (2) elimination of the time limit on payment of assistance to an aged tuberculosis or mental patient in a general hospital; (3) medical care for old-age assistance recipients comparable to that available to the medically indigent, who receive medical but not cash assistance; (4) liberalized State residence requirements; and (5) standards for housing rented to aged people on assistance.

November 18-22: The House Committee on Ways and Means held hearings on H.R. 3920.

1964

January 20-24: The Committee on Ways and means resumed the hearings begun the preceding November on H.R. 3920. (During its executive sessions which, continued until early in July, the Committee studied many alternatives to providing for the hospital and medical care of the aged. There was thorough consideration of the extent to which the program of Medical Assistance for the Aged (Kerr-Mills) had been implemented and of ways that it could be improved. After months of deliberation, the Committee decided to report out a bill that did not provide for hospital insurance or for improvement of the (Kerr-Mills) program.

February 10: President Johnson outlined a many-sided attack on the Nation's most serious health problems in a special message to Congress, *Health of the Nation.*

June 24: At the request of Representative King (who could obtain only 12 favorable votes in the Committee--one short of a majority--and seeking to avoid defeat of his bill), the Committee on Ways and Means agreed to postpone action on H.R. 3920.

July 1: Chairman Mills introduced H.R. 11865 providing a 5 percent increase in social security benefits and other improvements in the program but not including any kind of health-care proposal.

July 7: The House Committee on Ways and Means reported favorably to the House the Social Security Amendments of 1964 (H.R. 11865 — H. Rept. 1548).

July 29: H.R. 11865 was passed by the House by a roll-call vote of 388 to 8. The bill was debated under a rule that permitted only Committee amendments, and none were proposed.

August 6: The Senate Committee on Finance began hearings on H.R. 11865. Secretary Celebrezze in testifying on the bill said, ". . . H.R. 11865 is seriously lacking in the area of highest priority need. It fails completely to offer those past 65 an avenue through which they can afford and obtain adequate basic health insurance protection. It thus fails to come to grips with the gravest threat to financial security and peace of mind in old age.

"What is needed to provide security in old age, in sickness as well as in health, is

"First and most urgent, hospital insurance for the aged provided under the social security program so that older people would be assured of being able to meet this major item of expensive health care in a way consistent with dignity and self-respect.

August 17: During consideration of H.R. 11865, the Senate Finance Committee rejected three amendments which would have provided for financing of hospital insurance for the aged through social security. The amendments were: (1) S. 880, the Administration bill, defeated by a 6 to 11 vote; (2) a compromise plan sponsored by Senator Ribicoff of Connecticut to give social security beneficiaries the option of a $7 a month increase in cash benefits or a $2 cash increase in combination with a health insurance plan financed through social security, rejected by a 5 to 12 vote; (3) an amendment by Senator Javits, rejected by voice vote, providing hospital and nursing home care financed through social security for people over 65 whether covered by the system or not.

August 20: The Senate Finance Committee reported H.R. 11865 in substantially the same form passed by the House. The report (S. Rept. No. 1513) also contained the following minority views: "The committee-approved bill makes no provision for a program of insurance for hospital and related care for the aged and thus fails completely to meet the most desperate and urgent need of our older people. Until such protection is added to the cash benefits of our present social security program, economic security and peace of mind will continue to lie beyond the grasp of many millions of older Americans. . . .

"It is not enough to provide programs that come to the rescue after the elderly have exhausted their resources and savings, and perhaps, those of their families. We must adopt a way of preventing destitution and dependency.

" . . . social security hospital and nursing insurance would prevent indigency by helping older people meet their health costs before they have been reduced to indigency."

September 2: An amendment to H.R. 11865 providing medical care for the aged financed through social security was offered by Senator Gore of Tennessee. The amendment, which was similar to the Administration bill (H.R. 3920 and S. 880), was adopted by a roll-call vote of 49 to 44.

September 3: The Senate passed H.R. 11865 including health care by a vote of 60 to 28, after defeating by a vote of 23 to 64 an amendment proposed by Senator Prouty of Vermont to eliminate the health care program and increase social security benefits.

September 15: A conference committee was named to reconcile differences between House and Senate versions of the bill. During conference consideration of the differences involved, the House conferees voted 3 to 2 against any kind of social security health plan; Senate conferees voted 4 to 3 not to accept any bill unless some kind of hospital care was included. Since the Senate-House conferees failed to reach an agreement, no further action resulted in 1964.

1965

January 1: The Report of the Advisory Council on Social Security on the Status of the Social Security Program and Recommendations for Its Improvement pointed out that older people and disabled people have a special need for protection against the costs of hospital care and related services--they need more care and they have less money to pay for it--and recommended hospital insurance protection for them. The proposal covered inpatient hospital benefits, outpatient diagnostic services, extended-care facilities and home nursing services for social security beneficiaries.

January 4: President Johnson's *State of the Union Message* listed as an item of high priority "help for the elderly, by providing hospital care under social security and by raising benefit payments to those struggling to maintain the dignity of their later years."

January 4: Representative King of California introduced H. R. 1 to provide hospital insurance under the social security program and an increase in cash benefits Senator Anderson of New Mexico introduced S. 1, the Senate companion bill. The bills embodied the Administration's hospital insurance proposal and contained many of the same provisions which had been extensively considered by the Congress in 1964.

January 7: President Johnson's first legislative message to the 89th Congress, *Advancing the Nation's Health,* detailed proposals for a broad health-care program that he termed "practical, prudent and patient." The program included hospital insurance for the aged under social security and health care for needy children; top priority was given to his recommendation for a hospital insurance program for the aged, financed through the social security system.

March 23: The Committee on Ways and Means of the House of Representatives, after six weeks' consideration of H.R. 1, approved by a 17-8 vote a bill to replace the Administration's proposal with an unprecedented package of health benefits and social security improvements. During the years that the subject matter had been before it, the Committee had conducted more days of public hearings on hospital insurance than on any other matter within its jurisdiction in the same period. The vote was historic--the first time that the House Committee had acted favorably on a medical insurance bill for all older citizens.

March 24: H.R. 6675 was introduced by Representative Wilbur D. Mills, Chairman of the Committee on Ways and Means, as the "Social Security Amendments of 1965." The bill established two coordinated health insurance programs under the Social Security Act for people 65 or over: (1) a *basic* plan of hospital insurance and related care under the social security program, with financing through a separate payroll tax and trust fund; and (2) a voluntary *supplementary* plan providing for doctors' fees and other medical and health services, financed by $3 a month premium payments by each participant matched by an equal amount from Federal general revenues. Undergirding the two new insurance programs would be a greatly expanded medical care program for the needy and the medically needy. The bill also provided for an across-the-board 7 percent increase in social security benefits, for increasing the taxable wage base from $4,800 to $6,600, and for other changes.

April 7-8: The House Rules Committee cleared H.R. 6675 promptly for debate on the House floor and granted the Committee Chairman's request for a closed rule (limiting floor amendment of the measure). House debate on the bill began April 7, and it was passed, without amendment, on April 8 by a vote of 313 to 115.

April 28-June 24: The Senate Committee on Finance began public hearings on H.R. 6675, and called Secretary Celebrezze as the first witness. He discussed the provisions of H.R. 6675, and urged enactment of the bill. After extensive public hearings, the Committee began executive session consideration of the bill. Voting on the various provisions started May 25, and continued for nearly a month. During this prolonged period, the Committee, on June 17, approved two amendments sponsored by Senator Russell B. Long of Louisiana--one to provide for unlimited hospital and nursing home care, the other to impose an income test for receipt of hospital and related benefits. This action resulted from the Committee's concern that H.R. 6675 had not provided benefits for long-term illness. Upon reconsideration, the Committee on June 23 reversed its earlier decision, and by a 10 to 7 vote eliminated the income-test provision substituting one proposed by Senator Vance Hartke of Indiana to limit the number of days of hospital care. In its first favorable vote on a hospital insurance proposal, the Senate Finance Committee voted 12 to 5 on June 24 to report favorably H.R. 6675, with amendments. (The Committee had adopted 75 amendments to the House-passed bill.)

July 6-9: During floor debate on the Finance Committee's version of H.R. 6675, the Senate considered a multitude of amendments. By a vote of 51 to 41 on July 8, an amendment by Senator Curtis of Nebraska that would have reduced the Government's share of a patient's medical expenses by an amount equal to his Federal income tax was rejected. On the following day, by a vote of 64 to 26, the Senate turned down a recommittal motion by Senator Curtis to send the bill back to the Finance Committee with instructions to return the bill to the Senate by March 1, 1966, with a new health program patterned on the one available to Federal employees. After a 10-hour session and action upon numerous proposed amendments, the Senate at 8:00 p.m. July 9 passed the bill by a vote of 68 to 21. (The bill contained 513 changes from the version approved by the House; most of them, however, were not substantial and the major features of the two versions were the same.)

July 12-21: The bill was sent to a conference committee for reconciliation of differences between the two versions. The conference committee convened for its first negotiating session on July 14 and promptly settled a major point of disagreement: 60 days of hospitalization were provided with the patient paying a deductible of $40, and an additional 30 days with the patient paying $10 a day. Agreement was also reached on the limits for nursing home or extended-care services and for home visits by nurses. The compromise bill on July 21 conformed in all basic respects to the Administration's specifications for a comprehensive medicare program. It included: a hospital insurance program for persons 65 and over, administered by the Social Security system; an optional insurance plan for the elderly to help pay doctor bills and other medical costs; a 7 percent benefit increase retroactive to January 1, 1965; a general liberalization of social security benefits for retired persons and for widows, children, the disabled, and others.

July 26: The Conference Report was returned to both Houses for approval.

July 27: The House ratified the Conference agreement on the bill by a vote of 307 to 116.

July 28: The Senate by a roll-call vote of 70 to 24 gave final Congressional approval to the Administration's medicare-social security bill.

July 30: President Johnson signed H.R. 6675 to provide health insurance for the elderly, and it thereby became law (P.L. 89-97). The President signed the bill in Independence, Missouri, in the presence of former President Harry S. Truman, who opened the fight for such legislation in a message to Congress in 1945.

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Photo A

President Franklin D. Roosevelt signed the original Social Security Act into law on August 14, 1935. Among those present during the ceremony were (left to right) Rep. Robert L. Doughton (N.C.)--Chairman of the House Ways and Means Committee;Rep. Frank Buck (Calif.); Senator Robert Wagner (N.Y.); Senator Robert La Follette (Wisc.); Senator Augustine Lonergan (Conn.); Frances Perkins, Secretary of Labor; Senator William H. King (Utah); Rep. David Lewis (Md.); and Senator Joseph Guffy (Pa.).

Photo B

Thirty years later, former President and Mrs. Truman, Mrs. Johnson, and Vice President Humphrey were with President Johnson in the Truman Library, Independence, Missouri, when he signed the most extensive amendments (P.L. 89-97) ever made to the Social Security Act. Undersecretary of Health, Education, and Welfare Wilbur J. Cohen (third from left) stands with others who worked for enactment of the new law to be greeted by the President and presented with a pen used in signing the 1965 social security amendments. Former Federal Security Administrator Oscar R. Ewing is fifth from the left.

Photo C

The President also presented one of the pens he used to sign the monumental legislation to Robert M. Ball, Commissioner of Social Security, and exchanged reminiscences with Arthur J. Altmeyer, who helped set up the Nation's social security system and administered it for almost 20 years. Mr. Altmeyer, who became known as "Mr. Social Security," was chairman of the Technical Board (a Subcommittee of the Committee on Economic Security) appointed by President Roosevelt in 1934 to draft social security legislation. As a member of the original Social Security Board (1935), later Chairman of the Board (1937), and subsequently the Commissioner of Social Security, Mr. Altmeyer was top social security official until 1953 and is credited with having administered the new program so well that it has become a permanent feature of American life. Thirty-three congressional leaders also accompanied the President to Independence for the signing ceremony.

Photo A

Photo B

Photo C

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